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ATTACHMENT 3.1-A
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State/Territory: WISCONSIN

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/X/ Provided: /_/ No limitations /X/With limitations*

d. ~~Ambulatory services offered by a health center receiving funds~~ under section ~~329,~~ 330, or ~~340 of the Public Health Service Act~~ to a pregnant woman or individual under 18 years of age.

~~/X/ Provided: /_/ No~~ limitations ~~/X/With limitations*~~

3. Other laboratory and x-ray services.

Provided: /X/ No limitations /_/With limitations*

*Description provided on attachment.

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AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/No limitations /X/With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/No limitations /X/With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

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d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

[X] Provided: [ ] No limitations [ ] With limitations*

[ ] Not provided.

10. Dental Services.

[X] Provided: [ ] No limitations [ ] With limitations*

[ ] Not provided.

11. Physical therapy and related services.

a. Physical therapy.

[X] Provided: [ ] No limitations [ ] With limitations*

[ ] Not provided.

b. Occupational therapy.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

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State Rep. In. _____ Date Eff. 3/1/86

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Prosthetic devices.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Eyeglasses.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not provided.

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not provided.

c. Preventive services.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not provided.

d. Rehabilitative services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not provided.

b. Skilled nursing facility services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Intermediate care facility services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

18. [redacted] care (in accordance with section 1905(o) of the Act).

[redacted] Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WISCONSIN

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

X Provided: X With limitations*

___ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartem services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

23. Pediatric or family nurse practitioners' services.

X Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: WISCONSIN

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations /X/With limitations*

/ / Not provided.

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / /With limitations*

/X/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/X/ Provided: / / No limitations /X/With limitations*

/ / Not provided.

d. Nursing facility services for patients under 21 years of age.

/X/ Provided: / / No limitations /X/With limitations*

/ / Not provided.

e. Emergency hospital services.

/X/ Provided: /X/ No limitations / /With limitations*

/ / Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/X/ Provided: / / No limitations /X/With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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24. Pediatric nurse practitioner and family nurse practitioner services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

* Description provided on attachment.

State: Wisconsin

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

X provided _____ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
- __ State Approved (Not Physician) Service Plan Allowed
- __ Services Outside the Home Also Allowed
- X Limitations Described on Attachment

___ Not Provided.